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The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: a review of the literature

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Abstract

This paper reports the findings of a literature review of the health, social care and housing needs of older lesbian, gay, bisexual and transgender (LGBT) adults undertaken in 2006 for the Welsh Assembly Government. Peer-reviewed literature was identified through database searches of BNI, PubMed, CINAHL, DARE, ASSIA and PsychInfo. Follow-up searches were conducted using references to key papers and journals as well as specific authors who had published key papers. A total of 187 papers or chapters were retrieved, of which 66 were included in the study; major themes were identified and the findings synthesised using a meta-narrative approach. The main themes that emerged from the review were isolation, health behaviours, mental health and sexual health behaviours. The literature indicates that the health, social care and housing needs of LGBT older people is influenced by a number of forms of discrimination which may impact upon the provision of, access to and take up of health, social care and housing services. Understanding of the health, social care and housing needs of older LGBT people is limited and research in this area is scarce. The research which exists has been criticised for using small samples and for tending to exclude participants from less affluent backgrounds. The focus of research tends to be on gay men and lesbians; consequently, the needs of bisexual and transgender people remain largely unknown. Additionally, research which does exist tends to focus on a narrow range of health issues, often related to the health needs of younger LGBT people. Discrimination in various forms has a major impact on needs and experiences, leading to marginalisation of LGBT people both in the provision of health and social care services and neglect of these groups in public health research.

Keywords: bisexual and transgender, discrimination, gay, health, housing, lesbian, older people, social care

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Introduction

Members of various groups will have different needs, risks and expectations which impact on health, well-being and patterns of accessing health and social care services. Differences in life experiences exist between lesbian women, gay men and bisexual and transgender people and, as such, they represent a diverse group.

The review of the literature on lesbian, gay, bisexual and transgender (LGBT) older people's health, social care and housing needs aimed to identify key issues and map existing research in these areas. This paper reports on the findings of this review and outlines the existing evidence.

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Background

The research was undertaken for the Welsh Assembly Government and commissioned through the Wales Office of Research and Development for Health and Social Care (WORD) under the All Wales Alliance for Research & Development in Health and Social Care (AWARD) grant. The aim of the research was to provide baseline knowledge of the health, social care and housing needs of older LGBT people that could be used to inform policy and define research questions. The review contributes to the development of a comprehensive strategy for older people (defined as over 50 years of age) in Wales (Welsh Assembly Government, 2003), and the aims of inclusivity, equality and diversity which underlie the strategy.

Difficulties exist in assessing the numbers of LGBT older people within the population. In Britain, a recent estimate by HM Treasury suggested that about 6% of the British population were lesbian, gay or bisexual (Campbell 2005). No similar official estimates of the transgender population are available.

Methods

The meta-narrative review approach uses expert knowledge to conceptually define the research area. In order to scope out the research area and identify individuals with subject-specific expertise, we consulted researchers and campaigners on LGBT issues. An experienced researcher in lesbian and queer health was also invited to join the study team and advised throughout (the term queer health refers to a body of studies that aim to analyse the way in which lesbian and gay people and their health appear to have been constructed as less normal than heterosexual people by a medical and research establishment which is seen to have a strong heterosexual bias).

Following an initial mapping of the diversity of perspectives within the subject area and approaches to its study, conceptual papers were identified by following up footnote and endnote references of key papers. We sought to evaluate these according to generic scholarly criteria and contribution to subsequent work (Table 1). The purposive or snowball searching technique was supplemented by database and hand searching of major journals.

Search strategy

Peer-reviewed literature was identified through database searches (BNI, PubMed, CINAHL, DARE, ASSIA and PsychInfo). Search terms, 'health need', 'access', 'housing', 'social care' were combined with 'lgbt', 'lgb', 'gay', 'lesbian', 'transgender', 'bisexual' and 'older people'. The following inclusion criteria were applied:

1. papers published between 1985 and 2005;
2. studies which had been independently funded;
3. studies which examined health, social care or housing needs of either lesbian, gay, bisexual or transgender people, or all of these groups;
4. studies which used recognised qualitative or quantitative methods and validation.

A small minority of papers initially identified addressed older lesbian, gay bisexual and transgender issues specifically (10). Accordingly, the initial inclusion criteria were expanded to include studies that included younger participants and the second and fourth criteria were not applied. References were excluded if the focus fell outside the areas specified in the third inclusion criteria or the age range did not include older participants. In total 187 references were assessed and 66 included in the final review.

Throughout the review, themes and patterns emerging from the international, peer-reviewed literature were contextualised by reading of UK-wide and locally produced grey literature, identified using web searches and messages posted on public health and social policy mailing groups (public-health@jiscmail.ac.uk and health-equity-network@jiscmail.ac.uk). Reports and policy statements on lesbian, gay, bisexual and transgender older people were not extensive.

Synthesis

A number of categories relating to health experiences, social care and housing needs of older LGBT people were identified. The meta-narrative review method was selected in order to provide a structure within which to compare and contrast data and opinion from diverse sources.

During the 'mapping' phase, the methodological, conceptual and theoretical elements across papers were

Table 1 Inclusion criteria for seminal sources on lesbian, gay, bisexual and transgender older people's health, social care and housing needs (adapted from Greenhalgh *et al.* 2005)

1. Is the paper part of a recognised research tradition, that is, does it draw critically and comprehensively upon an existing body of scientific knowledge and attempt to further that body of knowledge?
2. Does the paper make an original and scholarly contribution to research into the health, social care or housing needs of lesbian or gay or bisexual or transgender older people?
3. Has the paper subsequently been cited as a seminal contribution (conceptual, theoretical, methodological or instrumental) by competent researchers in LGBT or older peoples' health, social care or housing needs?

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identified through an iterative process of discussion within the research team and key findings or claims across papers were summarised. Each primary study was evaluated for its validity and relevance to the review questions, key results extracted and collated and comparable studies grouped together.

Following discussion among the research team and the Welsh Assembly Government, a decision was made to include the broadest possible range of data within the review, including studies that were methodologically weak and opinion pieces.

As the full range of papers included in the review was broad, appraisal scores would not enable the objective comparison of paper quality. Nonetheless, measures were employed to increase quality, such as using two assessors to agree on relevance to the research questions and the separation of papers by type, so that primary research was not directly compared with opinion pieces. Any conflicting author interest such as institutional allegiance or employment by a campaigning organisation was also recorded.

Greenhalgh *et al.* (2005) point to the dangers of reviewers 'flying solo' in the literature that is poorly organised and presented and is not amenable to appraisal using standard tools. We sought to use additional measures to help protect against bias and the high level of agreement between researchers may appear to indicate that our conclusions were sound. However, high rates of agreement might simply indicate that we brought similar biases to understanding the relevance of the material and drawing conclusions from it. We therefore engaged the wider research team and policy leads in a process of testing the findings against their expectations and experience.

Quality assessment of primary research

The quality of primary research papers was formally assessed using standard quality assessment criteria for evaluating primary research papers from a variety of fields (Kmet *et al.* 2004). This evaluation method allows the systematic evaluation of both quantitative and qualitative primary research and across a broad range of study designs. Specific aspects of the paper, relating to methodology (e.g. 'Method of subject selection') and writing (e.g. 'Results reported in sufficient detail?') are scored with either a yes (2 points), partial (1 point) or no (0 points). The quantitative papers were assessed using 14 items, with nine items being potentially not applicable (n/a) due to the use of particular study designs. A summary percentage score was calculated by dividing total score summed across all applicable items by the highest possible score total [28 − (number of n/a × 2)]. The scores for qualitative papers was undertaken in a similar way, using 10 items with none being n/a (Kmet *et al.* 2004).

Table 2 Primary research papers

Author	Method	Participants	Age range (years)	Sample size	Quality (%)
Bauer and Welles (2001)	Questionnaire	Women	18–83	286	90
Bradford *et al.* (1994)	Survey	Lesbians	17–80	1925	70
Brotman *et al.* (2003)	Focus groups	Gay and lesbian 'seniors' also members of healthcare organisations and government bodies	Seniors	32	85
Cochran *et al.* (2003)	Surveys	All	25–74	2917	100
D'Augelli *et al.* (2001)	Survey	LGB	60–91	416	90
Hays *et al.* (1997)	Interviews	Gay men	65–77	12	65
Hughes and Evans (2003)	Questionnaire	Heterosexual and lesbian women	19–69	120	75
Johnson *et al.* (2005)	Questionnaire	GLBT	15–72	127	75
King *et al.* (2003)	Survey	Gay men, lesbians and heterosexual men and women	16–75+	2179	90
Lucco (1987)	Survey	Gay men & Lesbians	55–86	456	60
Mays and Cochran (2001)	Questionnaire	LGB	25–74	3032	95
Meyer (1995)	Interview	Gay men	21–76	741	100
Mills *et al.* (2004)	Interview	Gay men	18–70+	2881	100
Quam and Whitford (1992)	Questionnaire	Lesbians and gay men	50+	80	70
Shippy *et al.* (2004)	Questionnaire	Gay men	50–87	233	75
Stall and Catania (1994)	Survey	All	50+	2673	100
Valanis *et al.* (2000)	Various	All women	50–79	93 311	95
Warner *et al.* (2004)	Survey	GLB	Not specified	1285	80
Welch *et al.* (1998)	Postal questionnaire	Lesbian women	19–66	561	50
White and Cant (2003)	Interview	Gay men	25–63	30	55

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Table 3 Key findings

Author(s)	Method and participants	Key findings
Bauer & Welles (2001)	Questionnaire; women	13% reporting female only sexual partners reported a history of STDs. Of self-identifying lesbians 15% had been diagnosed with an STD but were only 27% as likely as women self-identifying as bisexual or heterosexual to obtain regular STD testing with older age predicting a decreased likelihood of testing.
Bradford *et al.* (1994)	Survey; lesbians	25% drank more than once a week, and 30% smoked cigarettes daily, 11% were occasional smokers. Over half of the sample had thoughts about suicide and 18% had attempted suicide. Women aged 55 years or older were least likely to have thought about suicide. The oldest group of lesbians was also least likely to report receiving treatment for anxiety or depression.
Brotman *et al.* (2003)	Focus groups; gay and lesbian 'seniors' also members of healthcare organisations and government bodies	The theme that emerged repeatedly and frequently was the profound marginalisation experienced in all aspects of social and political life. Lifelong experiences of marginalisation and oppression lead to mistrust of health and social services network and invisibility obstructs any possibility of developing sensitive and appropriate health, social service and long-term care alternatives.
Cochran *et al.* (2003)	Surveys; all	Gay/bisexual men evidenced higher prevalence of depression, panic attacks and psychological distress than heterosexual men. Lesbian women showed greater prevalence of generalised anxiety disorder than heterosexual women.
D'Augelli *et al.* (2001)	Survey; LGB	Gay men experienced negative feelings about being gay, tended to overuse alcohol and had suicidal feelings. Many associated these experiences with others' reactions to their sexual orientation. Conversely, good mental health was associated with higher self-esteem, a sense of social integration and more people being aware of their sexual orientation.
Hays *et al.* (1997)	Interviews; gay men	Few informants maintained positive relationships with members of their families of origin, relationships often breaking down because of disclosure of sexuality.
Hughes & Evans (2003)	Questionnaire; heterosexual and lesbian women	Lesbians with a history of sexual intercourse with men will run similar risks in terms of HPV, STD & HIV. HPV can also occur in women who have never had heterosexual intercourse. In terms of alcohol use, 16% of lesbians compared with 2% of heterosexual women reported that they were in recovery, while 5% of lesbians and 2% of heterosexual women reported that they drank more than twice a day on average.
Johnson *et al.* (2005)	Questionnaire; GLBT	73% of respondents indicated that they believed discrimination exists in retirement care facilities, while 74% believed such facilities do not include sexual orientation in their anti-discrimination policies. 60% did not believe they had equal access to social and health services, while 34% believed they would have to hide their orientation in a retirement facility. 98% indicated that a gay or gay friendly retirement care facility would be welcome.
King *et al.* (2003)	Survey; gay men, lesbians and heterosexual men and women	Using various measures gay men recorded significantly higher scores than heterosexual men (indicating psychological distress) and lesbians recorded higher scores than heterosexual women. More than one-quarter of gay men and almost one-third of lesbians reported that they had harmed themselves deliberately compared with one in seven heterosexual participants.
Lucco (1987)	Survey; gay men and lesbians	88.6% of the sample expressed a desire to move to continuing care for older homosexuals.
Mays & Cochran (2001)	Questionnaire; LGB	Homosexual and bisexual respondents were significantly more likely than heterosexual respondents to have at least one of the five psychiatric disorders assessed.
Meyer (1995)	Interview; gay men	Examined the mental health effects of three minority stressors and found that each of the stressors had a significant independent association with a variety of mental health measures. Men who had high levels of minority stress were two to three times as likely to also suffer from high levels of distress.
Mills *et al.* (2004)	Interview; gay men	Seven-day prevalence of depression in men who have sex with men was 17.2% higher than in adult US men in general.

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Table 3 (*Continued*)

Author(s)	Method and participants	Key findings
Quam & Whitford (1992)	Questionnaire; lesbians and gay men	Adjustment to later life depends largely on the acceptance of ageing, maintenance of high life satisfaction and being active in the gay and lesbian community.
Shippy *et al.* (2004)	Questionnaire; gay men	The social networks of gay men aged 50 years and older largely consisted of partners and friends, with friends being a critical element. Members of their families of origin were also reported to be included and those men who had children overwhelmingly indicated that sexual orientation did not stand in the way of their relationship.
Stall & Catania (1994)	Survey; all	The small subset of active gay or bisexual men in the sample reported higher rates of condom use and HIV testing than the wider sample.
Valanis *et al.* (2000)	Various; all women	Lesbian women had a higher body mass and diets lacking in fruit and vegetables. Where diets were similar in fat content, between 2% and 7% more lesbian and bisexual women surveyed were obese than their heterosexual peers; 15–17% of lesbians had been depressed compared with 11% of heterosexual women
Warner *et al.* (2004)	Survey; GLB	High rates of planned and actual deliberate self-harm and high levels of psychiatric morbidity among gay men (42%), lesbians (43%) and bisexual men and women (49%).
Welch *et al.* (1998)	Postal questionnaire; lesbian women	90.2% had consumed alcohol during the past year, 53.8% once a week and 24.4% monthly or less often; 48% of respondents perceived that lesbians used alcohol excessively; 75.8% had used cannabis at least once compared to 43% of a sample of the general population.
White & Cant (2003)	Interview; gay men	There were few cases cited of estrangement from families, daily support was provided by partners, ex-partners or friends rather than members of their families of origin.

This tool was not used to exclude studies based on a specific minimum quality standard but to gauge the impact of specific aspects of the evidence. The quality of the studies was generally quite high; however, the studies were mostly cross-sectional surveys/interviews of single groups; those comparing groups did little to control for potential confounders. Results are presented in Table 2.

Findings

Findings from the literature related to lifestyle factors, sexual health, mental health, relationships, housing and the impact of discrimination. A summary of key findings is presented in Table 3.

Lifestyle

The US-based, Women's Health Initiative (Valanis *et al.* 2000) found lesbian women of all ages had a higher body mass and diets lacking in fruit and vegetables. Additionally, where diets were similar in fat content, between 2% and 7% more lesbian and bisexual women surveyed were obese than their heterosexual peers (Valanis *et al.* 2000).

In respect of alcohol use, Hughes (2003) found that 16% of lesbians compared with 2% of heterosexual women reported that they were in recovery, while 5% of lesbians and 2% of heterosexual women reported that they drank more than two drinks per day on average.

In a study by Bradford *et al.* (1994), 25% of lesbians drank more than once a week, the percentages of those who drank daily were higher for older women. Thirty per cent of the sample smoked cigarettes daily, 11% were occasional smokers with middle-aged and older lesbians more frequent daily smokers than younger lesbians.

Welch *et al.* (1998) found 90.2% of the sample of lesbians had consumed alcohol during the past year; 53.8% drank alcohol once a week and 24.4% drank monthly or less often. Welch *et al.* maintains that patterns of drinking found are similar to that of other reports of New Zealand women's drinking; however, 48.1% of the respondents perceived that lesbians used alcohol excessively.

Welch *et al.* (1998) found that 75.8% of the respondents had used cannabis at least once compared with 43% of a sample of the general population, also that cannabis use did not decline with age to the extent it does with women in general.

Sexual health

Sexual identity does not necessarily predict sexual behaviour and some lesbians have a history of sexual intercourse with men (Hughes & Evans 2003). Where this is the case, lesbian women will run similar health

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risks as their heterosexual peers with regard to human papilloma virus (HPV), sexually transmitted diseases (STD) and human immunodeficiency virus (HIV). Among lesbians, as with heterosexual women, reported high-risk behaviours such as drug use and unprotected sex with bisexual or heterosexual men are likely to contribute to the prevalence of HIV infection (Hughes & Evans 2003).

One in five women who have never had heterosexual intercourse have HPV, also, although uncommon, female-to-female transmission of HIV is reported (Hughes & Evans 2003). These risks will be exacerbated by a tendency among lesbian women and service providers to assume that they do not require regular screening tests or for service providers to assume that they are heterosexual (MacBride-Stewart 2004a,b).

Bauer & Welles (2001) found that, of the 39 women in their study who reported only female sexual partners, 13% reported a history of STDs with only four of the 39 women reporting regular testing for STDs. Among women self-identifying as lesbians, 15% reported being diagnosed with an STD at some time; however, they were only 27% as likely as women self-identifying as bisexual or heterosexual to obtain regular STD testing. Older age predicted a decreased likelihood of testing.

With 10% of people aged over 65 years world-wide diagnosed with AIDS, AIDS in older people remains a problem (Centre for Disease Control and Prevention, 2002). Sexual contact has become the major cause of infection among Americans aged over 65 years. Two cross-sectional US-based surveys of 2673 Americans aged over 50 years reported that older people used fewer preventive measures (condoms and testing) than younger people. However, within the study, the small subset of actively gay or bisexual men reported higher rates of condom use (52% always used them, 9% never used them) and HIV testing (60% had been tested for HIV) than the wider sample (Stall & Catania 1994).

Mental health

Mental Health needs are often cited as a particular concern of LGBT people. Managing long-term stigma in the form of heterosexism and homophobia is suggested to contribute to higher risks of depression and suicide, addictions and substance misuse (Gillow & Davis 1987, Bradford & Ryan 1989, Rothblum 1994, Russell & Joyner 2001).

The Women's Health Initiative study found that 15–17% of lesbians had been depressed compared with 11% of heterosexual women (Valanis *et al.* 2000). Shippy *et al.* (2004) reported that a large minority (30%) of older gay men in this study described feelings of depression and a high level of unmet emotional need. D'Augelli *et al.* (2001) reported that gay men experienced negative feelings about being gay, tended to overuse alcohol and had suicidal feelings. Many associated these experiences with others' reactions to their sexual orientation. Conversely, good mental health was associated with higher self-esteem, a sense of social integration and more people being aware of their sexual orientation.

Results from Cochran *et al.* (2003) indicated that gay/bisexual men evidenced higher prevalence of depression, panic attacks and psychological distress than heterosexual men, while lesbian/bisexual women showed greater prevalence of generalised anxiety disorder than heterosexual women.

Meyer (1995) tested the mental health effects of three minority stressors and found that each of the stressors had a significant independent association with a variety of mental health measures. Men who had high levels of minority stress were two to three times as likely to also suffer from high levels of distress.

Mills *et al.* (2004) found that the 7-day prevalence of depression in men who have sex with men was 17.2% higher than in adult US men in general. Mays & Cochran (2001) found homosexual and bisexual respondents were significantly more likely than heterosexual respondents to have at least one of the five psychiatric disorders assessed.

Using measures such as the Clinical Interview Schedule and the General Health Questionnaire, King *et al.* (2003) reported that gay men recorded significantly higher scores than heterosexual men (indicating psychological distress); while lesbians recorded higher scores than heterosexual women. Additionally, more than one-quarter of gay men and almost one-third of lesbians reported that they had harmed themselves deliberately compared with one in seven heterosexual participants (King *et al.* 2003). Warner *et al.* (2004) also found high rates of planned and actual deliberate self-harm and high levels of psychiatric morbidity among gay men (42%), lesbians (43%) and bisexual men and women (49%).

Over half of the sample of lesbians in a study by Bradford *et al.* (1994) had thoughts about suicide, 18% had attempted suicide; however, women aged 55 years or older were least likely to have thought about suicide. The oldest group of lesbians were also least likely to report receiving treatment for anxiety or depression.

Relationships

Lipman (1986) notes that lesbian and gay people have more friends than heterosexuals of the same age, these friends also tend to be gay or lesbian and form 'families of choice' (Weston 1991). Positive aspects of gay and lesbian ageing have been widely described (Butler & Hope 1999, Healy 2002, Butler 2004): a number of studies

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report that older gay and lesbian people have greater life satisfaction, lower levels of self-criticism and fewer psychosomatic problems (Berger & Kelly 1986, Adelman 1990, Friend 1990, Kimmel 1995, Humphreys & Quam 1998, Barranti & Cohen 2000).

Quam & Whitford (1992) found that among lesbian and gay older people, adjustment to later life depends largely on the acceptance of ageing, maintenance of high life satisfaction and being active in the gay and lesbian community. Nonetheless, lesbian and gay older people can feel marginalised as ageism also exists within the gay and lesbian communities (Brotman *et al.* 2003). Isolation is likely to be a major threat to the well-being of older lesbian and gay people, placing individuals at higher risk of self-neglect, decreased quality of life and increased mortality (Quam & Whitford 1992, Peterson & Bricker-Jenkins 1996, Herdt *et al.* 1997).

Shippy *et al.* (2004) examined the social networks of gay men aged 50 years and older and found that they largely consisted of partners and friends, with friends being a critical element. However, social networks were reported to include members of their families of origin and those men who had children overwhelmingly indicated that sexual orientation did not stand in the way of their relationship. By contrast, Hays *et al.* (1997) found that few informants maintained positive relationships with members of their families of origin, relationships often breaking down because of disclosure of sexuality.

White & Cant (2003) identified people to whom the informants felt close or identified as confidants and found, although there were very few cases cited of estrangement from families, daily support was provided by partners, ex-partners or friends rather than members of their families of origin.

Housing

Older lesbian and gay people are more likely to live alone than are their heterosexual peers (Cahill *et al.* 2001, Brookdale Centre on Aging – Hunter College, 1999, Rosenfeld, 1999 cited in Butler 2004:31). However, those people who live alone may have partners who live separately. US-based surveys have shown that 40–60% of gay men and 45–80% of lesbian women have long-term partners at any one time (Cahill *et al.* 2001).

Older people in general are concerned about loss of independence; for lesbian and gay people who have experienced discrimination or imposed treatment regimes, dependence on social care or institutionalisation is suggested to be perceived as a real threat (Taylor & Robertson 1994, Claes & Moore 2000). Consequently, older lesbian and gay people are reported to delay entering residential care (Claes & Moore 2000). Additionally, it is suggested that signs of affection between lesbian and gay people within residential institutions have not been understood by the staff and as a result caused conflict (Brotman *et al.* 2003). Apart from a lack of support for 'families of choice', discrimination against gay and lesbian older people in residential setting may include incidences or threats of involuntary 'outing', neglect and physical and sexual assault (Bradford & Ryan 1987, Stevens & Hall 1988, Bybee 1991).

Johnson *et al.* (2005) found that 73% of respondents indicated that they believed discrimination exists in retirement care facilities, while 74% believed such facilities do not include sexual orientation in their anti-discrimination policies. Additionally, 60% of the respondents did not believe that they had equal access to social and health services, while 34% believed that they would have to hide their orientation in a retirement facility. An overwhelming majority (98%) indicated a gay or gay friendly retirement care facility would be welcome, echoing an earlier study by Lucco (1987).

Impact of discrimination

A major theme highlighted within the literature was the importance of discrimination and the impact that discrimination may have on access to health and social services. Older LGBT adults may experience various forms of discrimination, including ageism, heterosexism and homophobia, which will lead to marginalisation and invisibility (Hays *et al.* 1997, Claes & Moore 2000, Blando 2001, Brotman *et al.* 2003, Johnson *et al.* 2005, Price 2005). Such issues underpin much of the research highlighted in this review.

Generally, the sexuality of older people is not widely recognised. Price (2005) suggests that expressions of sexuality among older people are seen as problems to be managed or treated. As such, older lesbians, gay and bisexuals have been understood to be 'twice hidden' and to represent the most 'invisible of an already invisible minority' (Blando 2001).

Ageist assumptions are combined with presumptions of heterosexuality (Price 2005). Heterosexism is the assumption that all individuals are heterosexual and heterosexuality is more natural and normal than same sex sexuality. Social institutions and individuals operate this assumption which may result in discrimination towards or against LGBT people (MacBride-Stewart 2001).

Claes & Moore (2000) propose that as society prefers to see older people as sexless and as lesbians and gay men are primarily viewed by their sexuality it is not surprising that elderly lesbians and gay men experience even greater homophobia than their younger counterparts.

As a consequence of discrimination, it is suggested that LGBT people are less likely to access health services or to disclose their sexual identity when they do. Past

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experiences of discrimination or fears of encountering further discriminatory practice appear to contribute to health risks as LGBT older people seek to avoid routine health care and fail to claim social and housing support when it is needed (Harrison & Silenzio 1996, Owen 1996, Risdon 1998, Robertson 1998). Lesbian and gay patients have reported negative reactions from healthcare providers which include embarrassment, anxiety, rejection or hostility, curiosity, pity, condescension, ostracism, withholding treatment, detachment, avoidance of physical contact and breach of confidentiality (Brotman *et al.* 2003).

The onset of disability in later life may contribute to a greater risk of 'outing' of LGBT people by care providers, in part by the exposure of domestic arrangements or living circumstances (Price 2005). For those who have spent a lifetime protecting the privacy of their sexuality, this is likely to be a real cause for concern. Consequently, it is suggested that older LGBT people may prefer not to claim benefit for a partner if their relationship is not public (Age Concern, 2002) and can be anxious about completing official documents that require information about next of kin (Rankow 1995, Price 2005). Where LGBT couples may live separately but be financially inter-dependent, accordingly, where one member of the couple needs care, the financial effects on the other may be great, but remain unrecognised (Age Concern, 2002).

Recognition of 'families of choice' to older LGBT people can impact on support and care and difficulty in obtaining information from hospitals has been reported (Price 2005). Members of 'families of choice' also note that insufficient recognition is granted to them in terms of visiting, decision making and caring for their friend or partner (Irving *et al.* 1995, Turner & Catania 1997, Ryan *et al.* 1998).

Discrimination is seen by LGBT older people to be prevalent in elderly care system. In addition, through the unique environment of voluntary care and shared housing, older LGBT people may come into contact with other residents who may hold discriminatory attitudes (Krauss Whitbourne *et al.* 1996, Peterson & Bricker-Jenkins 1996, Daley 1998, Gold *et al.* 1999).

Further research identified by the review

The variation in experiences of sexual minority status and ways in which ethnicity may interact with this have begun to be examined in research in the UK and elsewhere (Bhugra 1997, SAFRA Project, 2003, Graziano 2004, Gilley & Co-Cke 2005). However, we could find no research in these areas relating specifically to older people, ethnicity or sexuality or gender identity.

Most research on LGBT people of all ages focuses on towns or suburban environments. However, studies in Australia and Canada (Lindhorst 1997, Mancoske 1997, Riordan 1998, McCarthy 2000) report higher levels of HIV infection and institutional discrimination in rural communities, but also describe how LGBT people have actively sought to develop community structures.

Finally, work on disability and sexual identity (McAllan & Ditillo 1994) seeks to counter prejudice regarding the asexuality of disabled people. O'Toole & Brown (2003) emphasise the autonomy of disabled lesbian women and describe how strategies and resources were developed to meet their mental health needs within the lesbian community and outside it.

Discussion

Higher rates of behaviours such as smoking, alcohol use, obesity and low intake of fruit and vegetables will put lesbians at a greater risk of cardiovascular disease than their heterosexual counterparts (Hughes & Evans 2003). However, evidence on rates of drug and alcohol misuse in the lesbian community is conflicting and of variable quality, with higher rates compared with the heterosexual population being contested (Welch *et al.* 1998).

Welch *et al.* (1998) asserts that while early studies used samples at least partly derived from gay or lesbian bars which would have biased results, recent studies have avoided sampling only bar patrons and found no difference between drinking rates in heterosexual women and lesbian women. However, there persists a belief that higher rates of alcohol use exist within lesbian communities. This may reflect beliefs rather than realities as such issues exist alongside a greater sensitivity within lesbian communities over excessive drinking (Welch *et al.* 1998, Hughes 2003).

In respect of STDs, low levels of testing for women self-identifying as lesbian, especially in the older age groups are consistent with the incorrect perception within lesbian communities and among healthcare professions that STD testing is not critical because sexual relations between women involve negligible risk (Bauer & Welles 2001).

As gay, lesbian and bisexual behaviour has been pathologised and transgender identities in particular have been seen as a sign of poor psychological adjustment, historical assumptions may bias research towards an assumption that these groups suffer from higher rates of mental distress (Mirowsky & Ross 1999). While heterosexism may influence the way in which research itself is framed, higher rates of depression among lesbian, gay, bisexual and transgender people are routinely reported in the literature,

Relatively robust associations between experiences of discrimination and indicators of psychiatric morbidity were found by Mays & Cochran (2001); research indicates that lesbian, gay and bisexual persons are more

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likely to experience discrimination than heterosexual persons (Bradford *et al.* 1994, King *et al.* 2003, Warner *et al.* 2004).

The scope of discrimination and its effects on patterns of accessing services among LGBT older people was a recurrent theme throughout the literature. Another theme was the reluctance of LGBT people to disclose their sexuality to health professionals; alternately, LGBT may provide clues to their sexuality that only those health and social care providers attuned to the experiences of under-represented groups would be able to pick up (MacBride-Stewart 2001).

Issues closely connected with discrimination were those of the failure of agencies to acknowledge the needs of these groups as users of health, mental health and social care services.

Limitations in lesbian, gay, bisexual and transgender research

Boehmer (2002) argues that the lack of uniform definitions and measures for LGBT persons in behaviour and identity as well as different sampling strategies severely limit the generalisability of study results. Cahill *et al.* (2001) note that serious limitations decrease the value of much research on LGBT groups in the USA. The majority of research addresses the experiences of gay men, fewer the perceptions and concerns of lesbians and fewer still the experiences of bisexual and transgender people. Brotman *et al.* (2003) asserts that research that claims to include bisexual and transgender populations often fails to do so. This will act to reinforce the marginalised and invisible status of bisexual and transgender groups. This review found no research which included results on transgender groups.

As long as research focuses on the experiences of people who are comfortable with reporting their sexuality or gender identity, samples will consist only of individuals prepared to self-identify. Given the continuing impact of discrimination, it is inevitable that many people will not self-identify, for example Warner *et al.* (2004) found that the characteristics of bisexual respondents suggested that they form a unique group in terms of reticence about their sexuality.

If LGBT persons choose not to disclose their identity, even where anonymity or confidentiality is assured, this will impact on all research with these groups. Orel (2004) interviewed a range of participants, including some who had not disclosed their sexuality to others. Orel found that the needs of those who were 'in the closet' differed considerably from those of who publicly self-identified as lesbian or gay.

Institutional and historical factors related to heterosexist assumptions determine priorities for research; this has led to a focus on mental health needs, HIV/AIDS, breast cancer and alcohol misuse. A number of commentaries on the health and social care needs of older LGBT people have noted that the emphasis on HIV/AIDS in younger LGBT groups is excessive (Claes & Moore 2000, Butler 2004, Orel 2004). Hart & Flowers (2001) note that few studies address risks of cancer, coronary heart disease or non-HIV psychiatric morbidity among gay men, despite high prevalence of these risks to health in heterosexual communities.

A search of MEDLINE by Boehmer (2002) between 1980 and 1999 found that 56% of the research on LGBT people was disease specific in the context of STDs, with 52% of the research disease specific in the context of HIV or AIDS, most articles focussing on gay and bisexual men (80% and 39% respectively). Additionally, despite an expansion of breast cancer research in the general population, lesbians and bisexual women were neglected.

Sexual orientation and transgender identity need to be recognised as cultural and social categories that shape all health experiences; however, Boehmer (2002) found that public health research has neglected this population and that LGBT persons are under-represented as explicit research subjects. Another important shortcoming within LGBT research is the omission of race/ethnicity as dual minority status – sexual and racial/ethnic – affects illness, health needs and behaviours. Where studies do not reflect the ethnic, class and economic diversity of lesbian, gay, bisexual and transgender groups the distinctive needs of these groups are likely to be silenced or misrepresented.

Conclusions

Although the older LGBT population is growing at the same rate as that of older people in general, the needs and experiences of these groups have been largely disregarded by the majority of health and social care institutions and bodies. Current practices in health and social care will, at best, marginalise the needs of these groups. Additionally, given the historical role of health and social care in suppressing these identities, older LGBT people appear likely to continue to avoid disclosing their sexual identity, contributing to systemic failures of health and social care services to meet the needs of these groups, thereby sustaining discrimination and inequality of care.

The invisibility of lesbian, gay, bisexual and transgender older people in health, social care and housing settings thus has two dimensions: apart from being a consequence of non-disclosure due to fear of discrimination, it is also imposed through the heterosexual practices of institutions and healthcare professionals. Where LGBT older people are marginalised and invisible,

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service providers are able to knowingly or unknowingly overlook and discriminate against their needs.

Reflecting this bias, research on the health and social care needs of older people fails to reflect the full spectrum of sexualities and gender identities to which these groups subscribe.

Future research direction

As older people and their carers find themselves potentially facing reduced mobility and various kinds of disability, studies of the strategies taken to cope with disablement, mental distress and relationships with services are particularly needed for older lesbian, gay, bisexual and transgender people.

Theoretical work (Sedgewick 1991, MacBride-Stewart 2001, Hall 2003, Lance & Tanesini 2005) has raised questions about the role of institutions, particularly medicine, psychology and associated health professions and organisations in establishing sexual and gender norms. Practices of defining other sexualities and gender identities as being deviant are likely to be of key importance for older lesbian, gay, bisexual and transgender people. This review found no primary research involving interviews with individuals and groups or observation within health and social care institutions.

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